

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8206	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/18/2011
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE HOUSE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 250 BELLEBROOK RD BRISTOL, TN 37620		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 001	1200-8-6 Initial Comments During the annual Licensure survey and complaint investigation number TN 27746, conducted on May 18, 2011, at The Cambridge House, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 001			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

6XTQ11

If continuation sheet 1 of 1

JUN 01 2011